COUNTY OF SAN DIEGO – HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES

Mental Health Services Act Innovation Projects

Evaluation 2013

.

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

Innovation Project Evaluation
Developed by the County of San Diego Behavioral Health Services,
Behavioral Health Division, Quality Improvement Unit

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Introduction

The Mental Health Services Act (MHSA), Proposition 63, was approved by California voters in November 2004 and became effective January 1, 2005. The MHSA provides funding for expansion of mental health services in California. As required by the law, the County of San Diego, through the Health and Human Services Agency (HHSA) Mental Health Services Division, has completed the MHSA Innovation Program and Expenditure Plan. The MHSA Innovation Plan outlines proposed MHSA-funded programs and services to be provided locally. Innovation programs provide services that are novel, creative and/or ingenious mental health practices/approaches that are expected to contribute to learning, which are developed within communities through a process that is inclusive and representative, especially of unserved and underserved individuals.

The County's MHSA Innovation Plan will be updated annually based on funding revisions and other program considerations. New programs will be added based on funding availability. The MHSA provides access to services for identified unserved/underserved clients in new or expanded programs, but may not replace or supplant existing services. Services provided through MHSA support the County's adopted Live Well, San Diego! initiative by enabling participants with behavioral health needs and the general public to access necessary resources and thereby lead healthy and productive lives.

In accordance with the MHSA ***Vision Statement*** and ***Guiding Principles***, services are designed to adhere to the following principles:

- Cultural and linguistic competency
- Promotion of resiliency in children and their families, and recovery/wellness for adults and their families
- Increased access to services, including timely access and more convenient geographic locations for services
- Services that are more effective, including evidence-based or best practices
- Reduced need for out-of-home and institutional care, maintaining clients in their communities
- Reduced stigma towards mental illness
- Consumer and Family participation and involvement
- Increased array and intensity of services
- Screening and treatment for persons with dual diagnoses
- Improved collaboration between mental health and other systems (education, law enforcement, child welfare, etc.)
- Services tailored to age-specific needs
- Address eligibility gaps by serving the uninsured and unserved

HHSA and BHS Vision, Mission, and Guiding Principles

All Innovation Projects are in alignment with the HHSA and Behavioral Health Services' vision, mission, and strategy/guiding principles.

County of San Diego, Health and Human Services Agency

Vision: Healthy, Safe, and Thriving San Diego Communities
Mission: To make people's lives healthier, safer, and self-sufficient by delivering essential services.

Strategy:

1. **Building a Better System** focuses on how the County delivers services and how it can further strengthen partnerships to support health. An example is putting physical and mental health together so that they are easier to access.
2. **Supporting Healthy Choices** provides information and educates residents so they are aware of how choices they make affect their health. The plan highlights chronic diseases because these are largely preventable and we can make a difference through awareness and education.
3. **Pursuing Policy Changes for a Healthy Environment** is about creating policies and community changes to support recommended healthy choices.
4. **Improving the Culture from Within**. As an employer, the County has a responsibility to educate and support its workforce so employees "walk the talk." Simply said, change starts with the County.

Behavioral Health Services

Vision: Safe, mentally healthy, addiction-free communities
Mission: In partnership with our communities, work to make people's lives safe, healthy and self-sufficient by providing quality behavioral health services.

Guiding Principles:

1. Support activities designed to reduce stigma and raise awareness surrounding mental health, alcohol and other drug problems, and problem gambling.
2. Ensure services are outcome driven, culturally competent, recovery and client/family centered, and innovative and creative.
3. Foster continuous improvement to maximize efficiency and effectiveness of services.
4. Maintain fiscal integrity.
5. Assist employees in reaching their full potential.

Mental Health Services Act Innovations Projects
INN-01 Wellness and Self-Regulation for Children and Youth Evaluation 2013

Program Name: **Wellness and Self-Regulation for Children and Youth**
Program Start Date: **October 15, 2010**
Program End Date: **October 14, 2013**

Purpose

1. **Purpose:**
   The Wellness and Self-Regulation for Children and Youth Innovations Project is an MHSA funded program. It was awarded to both New Alternatives Inc. for adolescents, ages 12 to 18 in the Rate Classification Levels (RCL) 12 and 14, and to San Diego Center for Children for children ages 6 to 13 in RCL 12. The goal of this program was to address the specific physical, emotional, and relational challenges faced by these children and youth. Given their circumstances, these children and youth are more likely to face health challenges such as obesity, diabetes, depression, anxiety, post-traumatic stress, and other life challenges.

2. **Explanation of Purpose:**
   The Wellness and Self-Regulation Program offered these youth an array of alternative, holistic interventions to produce a positive impact on their mental and physical health. These alternative treatment strategies focused on teaching youth multiple ways to reregulate functioning in areas such as arousal level, mood, physical health, mental health, social functioning, sleeping patterns, eating habits, family wellness, frustration management, and sense of self.

Learning Objectives

1. **Learning Objective (#1): Nutrition**

What We Hoped to Learn: The impact of nutrition on health, weight, and behaviors.

What We Learned: Much was learned throughout this process. First, this program highlighted the importance of a proper nutritional base. The first change implemented to one of the campuses was the menu. It went from a standard school lunch to a menu based on the Mediterranean diet created by the Kitchen Manager and a consulting Clinical Nutritionist. This diet maximized nutrition while minimizing sugar intake. The food was so important that it became predictable when one might see an increase in behaviors. For example, the school staff knew when the teens did not eat the full available breakfast and instead ate only the sweet foods (only the pancakes and syrup when there were pancakes, eggs, and sausage). Individuals were more likely to exhibit negative behaviors after the insufficient breakfast due to a drop in blood sugar levels after breakfast. Furthermore, the staff noticed a decrease in weight management and behavior improvement with an increase in junk food during certain holidays or times of year when there were parties, on-campus visitors, and off-campus visits.

2. **Learning Objective (#2): Motivational Interviewing**

What We Hoped to Learn: The impact of incorporating motivational interviewing during staff's interactions with the youth.

What We Learned: As part of the wellness and self-regulation program, the staff learned Motivational Interviewing. This technique was also supported by the socialization program, WhyTry. Staff was trained and encouraged to interact with the youth in a more effective way. Power struggles were avoided and the youth were empowered. This was both more effective with the youth and more encouraging for the staff. This change in approach is one reason for the change in campus culture.

3. Learning Objective (#3): Medication Tracking

What We Hoped to Learn: By tracking the youth's medication to see if there was a decrease in medication after involvement in the program.

What We Learned: Tracking medication in order to measure effectiveness of this program was not significant. The percentage of discharged teens who experienced a decrease in medication per diagnostic category was an average of 15.6 percent. Because medication use is a complex and multifaceted issue, different methods for tracking medications were discussed prior to implementation. Different medications are successful for treating different symptoms for different people. Also, teenagers are in a state of development with their bodies changing. Changes in dosages of medications are common based on their growth. In addition, RCL 12 and 14 programs are designed to treat children and youth with more severe diagnoses and symptoms. Medication use is more prevalent among this population. It was agreed to track number of medication per category, such as antidepressants and antipsychotics. Dosage and frequency were not tracked.

Though there was no significant decrease in psychotropic medication use, there was an observable decrease in the need for the regularly prescribed stool softener. Chronic constipation is often the side effect of psychotropic medications, not to mention the result of a poor diet. The teens had become familiar with constipation and taking the stool softener. After the wellness program began, they were amazed at how this changed when the new menu was implemented.

4. Learning Objective (#4): Mood Surveys

What We Hoped to Learn: By tracking the youth's moods to see if there was an increase or decrease in the youth's mood during their involvement in the program.

What We Learned: Mood surveys were administered to measure feeling happy, sad, calm, or angry. Originally these were to be administered daily and it was changed to weekly to avoid the youths' frustration with the survey frequency. Despite this change in frequency of administering the survey, the youth still became frustrated. Efforts were made to make it more fun, interesting, and less bothersome. However, the youth began to refuse, purposefully score the same every time, or simply scribble on the paper. It was concluded that mood surveys do not offer valuable information. Perhaps if they were administered monthly, there may have been more compliance. In addition, the psychological assessments provided a valid and reliable method for measuring psychological health. Thus, the mood surveys may not be necessary in future wellness programs.

5. Learning Objective (#5): Cholesterol, Blood Sugar, Blood Pressure

What We Hoped to Learn: To determine if there is a change in cholesterol, blood sugar, and blood pressure as a result of wellness interventions.

What We Learned: The large majority of youth measured normal cholesterol, blood sugar, and blood pressure levels, thus there was no significant change observed. However, few teens (average of 10 throughout the program) with high cholesterol or who were pre-diabetic or diabetic experienced improvements in these areas. In the future, these measurements can be reserved for the youth who specifically experience or express concerns with cholesterol, blood sugar, or blood pressure. These measurements could be obtained at intake or if concern arises, and then monitored quarterly. This approach would be less intrusive and more cost-effective.

6. **Learning Objective (#6): Heart Rate**

What We Hoped to Learn: To determine if there is a change in heart rate as a result of involvement in wellness interventions.

What We Learned: The Wellness Licensed Vocational Nurse (LVN) obtained heart rate measurements weekly. Heart rate changes showed insignificant results. It was very difficult to obtain this measurement at the same time each week, and many teens refused, thus creating fluctuation in readings and deeming data invalid. Heart rate did not prove to be necessary for tracking physical health improvements.

Analysis of Program Effectiveness

1. **Changes or Modifications during Implementation:**

   The Wellness and Self-Regulation contract required some modifications to its required elements in order to improve its effectiveness, efficiency, and to more easily coordinate with programs already in place such as mental health clinics and schools.

   Initially, the contract required five wellness activities to be offered per day. At New Alternatives Inc. wellness activities were between 45 and 60 minutes in duration, thus, to add five hours of wellness activities to the time between school, clinical hours, dinner, and bedtime was not feasible. There simply was not enough time in the day. Thus, the requirement for daily wellness activities was adjusted to three to five activities per day. This allowed flexibility to schedule activities within the schedule.

   Next, mood surveys were intended to be administered to the youth daily. The mood surveys were a Likert scale survey measuring a continuum between happy and sad, and angry and calm. However, experience informed the program directors that the youth would not comply with completing the surveys daily. The mood survey administration was changed from daily to weekly.

   In order to take a deeper look at the psychological impact of the wellness and self-regulation program, the directors suggested adding valid and reliable psychological assessments to the outcome data. Administration of psychological assessments was conducted upon intake and discharge, and sometimes at six-month intervals to ensure a pre and post score. Three assessments used widely in psychological research were chosen to measure anxiety, depression, and post-traumatic stress (RCMAS, CDI, UCLA-PTSD Index).

2. **Impact on Participants:** The program indicated to have positive results on the participants due to the change of nutrition resulting in effective weight management and a reduction of negative behaviors. The training and implementation of staff in motivational interviewing also resulted in a change in campus culture as it empowered the youth and encouraged the staff in their work.

3. **What Was Learned:** Nutrition was deemed extremely important to the youth's physical and mental health. In addition, the staff's implementation of motivational interviewing stressed the youth's resilience and empowered them in decision making. The tracking of mood, cholesterol, blood sugar, blood pressure, heart rate, and medication proved to be more of a stressor on staff and the youth and will not be recommended for continued program management or future program implementation.

4. **Recommended for Replication? YES**

   Although the MHSA wellness and self-regulation contract ended October 14, 2013, the wellness program at New Alternatives, Inc. continues as the program had a built-in sustainability plan. The Wellness Director assembled a team of Wellness Leaders to assume the responsibilities of the wellness program. Together they lead daily wellness activities, provide nutrition education, facilitate WhyTry socialization groups, role model healthy behaviors, and educate the youth and staff about wellness issues.

   Each unit on campus designed their own unique schedule based on the interests of the teens, which include activities in the five areas of wellness including, but not limited to drumming, fitness, dance, art and culture, creative writing, food preparation, nutrition education.

   The Wellness Leaders participated in transition activities to signify transition of the wellness program from the consultants to the new leaders. These activities involved a mural including every teens' and staff's wellness statement and a special ceremony to "pass the wellness torch" for every wellness consultant.

   In addition, the implementation of sensory integration and a sensory room began. The use of sensory integration to promote healthy self-regulation in teens has been effective and congruent with the trauma-focused nature of the wellness program. Sensory integration education allows teens and staff to identify warning signs and initiate sensory interventions and coping skills to prevent escalation of behaviors.

5. **Lessons Learned in Implementation:**

   This experience determined what elements would be beneficial for future wellness programs and what elements are not necessary. The following is a list of elements that are not necessary for the success of future wellness programs.

   - Weekly mood surveys – eliminate completely.
   - Quarterly blood draws – reserve for specific youth with health concerns.
   - Heart rate and blood pressure measurements – reserve for specific youth with health concerns.
   - Medication tracking – this is a difficult category to track for an age group who is growing and who experiences a particular high level of trauma and diagnoses. Specific medication tracking measures identifying type, dose, and times per day, may be helpful in gaining more insight into the wellness program's effect on medication use. This would require adequate staffing.

6. **Program Cost-Effectiveness:**

   In order to cut costs, the number of wellness consultants can be integrated into each facility. Professional wellness consultants were an integral part of this contract and their expertise in wellness benefitted all involved. Wellness activities that require professional certificates or intensive training such as nutrition, yoga, meditation, or martial arts would benefit the most with help from a professional consultant. However, staff with experience in particular wellness areas such as cooking, fitness, gardening, music, relaxation, and art can lead these activities.

Next Steps/Recommendations

Program has been discontinued; however, effective elements have been incorporated into existing programs since the philosophy of the program is well aligned with *Live Well! San Diego*.

Mental Health Services Act Innovations Projects
INN-02 HOPE Connections Evaluation 2013

Program Name: **HOPE Connections Peer and Family Engagement Project**
Program Start Date: **July 1, 2011**
Program End Date: **December 31, 2014**

Purpose

1. **Purpose:**
   HOPE Connections offers support to persons experiencing mental health challenges and their family members from the unique perspective of "someone who has been there." HOPE Connections utilizes peers, clinicians, and family members to assist clients in navigating the County of San Diego's behavioral health system, particularly during significant life transitions such as the initial engagement with behavioral health services. Additionally, HOPE Connections aims to reduce the need for hospitalization, reduce stigma, and foster independence in clients while they navigate behavioral health services.

2. **Explanation of Purpose:**
   HOPE Connections offers peer support and family engagement to clients and their families in three levels of care throughout San Diego County's Behavioral Health Services: 1). The County's Emergency Psychiatric Unit (EPU); 2). San Diego County Psychiatric Hospital (SDCPH); and 3). Designated outpatient mental health clinics. Culturally and linguistically competent support staff offers referrals, side-by-side coaching, assistance with reintegration into the community, linkages to appropriate mental health services, and help with navigating both behavioral and primary health care systems in an effort to encourage outpatient service utilization and recovery. HOPE Connections has also developed an education curriculum to train peer specialists and family members to serve as an effective bridge between primary health and behavioral health care.

Learning Objectives

1. **Learning Objective (#1): Peer Engagement**

What We Hoped to Learn: Does having peer specialists at the clinic site produce better client recovery outcomes?

What We Learned: Preliminary analysis of recovery measures such as employment status and living situation look promising for those clients who enrolled in the program when compared with those who were contacted but chose not to enroll or were not eligible due to a primary substance abuse issue. Further analysis will be conducted of outcome data after the project ends on 12/31/14.

2. **Learning Objective (#2): Building Trusting Relationships with Clients and Family**

What We Hoped to Learn: Are peer specialists able to build trust with clients and families and make them feel less overwhelmed?

What We Learned: Satisfaction data will be reviewed at the end of the project to evaluate how well peer and family staff were able to engage and assist clients and their families.

3. **Learning Objective (#3): Service Pattern of Clients Engaged at EPU**

What We Hoped to Learn: Does initial client engagement at the EPU by peers and family lead to improved access and utilization of behavioral health services?

What We Learned: Preliminary data suggests that involvement with the program's peer specialists may have increased the utilization of outpatient mental health services at a higher rate than clients who did not have support through the HOPE program following their EPU or SDCPH presentation. At the end of the project, further analysis will look more closely at this metric.

4. **Learning Objective (#4): Role of Family Involvement in EPU Outcomes**

What We Hoped to Learn: Does an effort to include the family members of clients contribute to better outcomes in the EPU?

What We Learned: Increased family involvement served as an alternate source in re-connecting with clients post discharge and an important tool in utilizing the clients' natural resources in the community. While this proved very helpful for both staff and clients, further data would need to be gathered to establish a link between family involvement and better outcomes in the EPU.

5. **Learning Objective (#5): Relationships Between EPU Engagement and Client Retention**

What We Hoped to Learn: Does effective engagement and linkage by the EPU HOPE Connections team result in greater client retention in behavioral health services?

What We Learned: Metrics are currently in place to track individuals who have been linked to care but an analysis has not yet been completed to determine whether those clients who were linked to mental health care were also retained in care.

6. **Learning Objective (#6): Relationships Between Peer/Family Support and Long-Term Recovery**

What We Hoped to Learn: Do peer and family supports result in positive. long-term recovery outcomes for clients?

What We Learned: Various metrics regarding increased linkages to care, employment status and living situation have been positive. Additional analysis will be conducted at the project's end which will provide more data that speaks to this objective.

7. **Learning Objective (#7): Effectiveness of Client-Centered, Recovery-Oriented Services within the EPU & Outpatient Clinics**

What We Hoped to Learn: Can voluntary, recovery-oriented, client-driven services be successful and change staff attitudes toward recovery within the EPU and outpatient clinic environments?

What We Learned: Through the use of peers and family, HOPE Connections has been able to educate and support clients, their families, and the community in accessing resources while they navigate

mental health services. The following is a sampling of positive feedback the program has received thus far.

"I simply love this program – and combined with Bridges – the experience of our patients in the EPU has improved immeasurably. Thank you for your vision – and for broadening mine as well – I never knew what we were missing." – Dr. Michael Krelstein about HOPE Connections

"Just wanted to send you a message recognizing Ms. Julie Nicholas for her great work this evening with a challenging patient. She volunteered to help with an appropriate intervention and facilitated a successful outcome with the patient for all of us here at the EPU. I sincerely appreciate her assistance." – Dr. Carl Taswell about HOPE Connections

8. **Learning Objective (#8): Effectiveness of Peer Engagement Strategies within Age, Ethnic, and Cultural Groups**

What We Hoped to Learn: Are peer engagement strategies effective with certain age, ethnic, and cultural groups? Are these results strong enough to inform practice for this program and other programs in San Diego County?

What We Learned: Basic demographic information has been collected for the program but specific analysis has not yet been completed which would indicate whether peer engagement strategies have been particularly effective within one group or another.

9. **Learning Objective (#9): Generalizability of Program Model for other San Diego Emergency Departments**

What We Hoped to Learn: Can this program model be generalized to other emergency departments in San Diego County hospitals to provide support and linkage to clients and families?

What We Learned: It appears, with adequate funding, that this model could easily be generalized to other emergency departments in San Diego hospitals. Preliminary evaluation results demonstrate that providing support and linkage to clients and families by peer specialists and family specialists are promising practices that may support increased utilization of outpatient treatment and a reduction in unnecessary hospitalizations.

Analysis of Program Effectiveness

1. **Changes or Modifications during Implementation:**

   On June 30, 2013, the .5 full-time equivalent (FTE) community-registered nurse (RN) position was increased to 1.0 FTE to better meet the needs of the clients.

2. **Impact on Participants:**

   "I can't thank you enough for nudging me into the right directions and bringing these helpful people into my life. Since I've met you, you've made the biggest difference on my recovery more than anyone else. It seems as though you have the power to open these doors leading to my better life. Sincerely I

appreciate your wise guidance, gentle encouragement, and strong support. I have begun to HOPE." – Client about HOPE Connections Peer Support Specialists

"HOPE Connections, several messages of thank you are due. Thank you, Fay, for seeing me yesterday at the office and adjusting the topic according to a pressing need that has arisen. I look forward to our next meeting. You showed compassion and concern, as did Anita, who kindly contributed worthwhile information and guidance." – Client about HOPE Connections Peer Support Specialists

3. What Was Learned:

The increase in RN hours to the HOPE Connections team enhanced effectiveness by providing additional support that other members could not provide. The community RN assists in connecting clients that were not accepted into mental health clinics by linking them to Primary Care Physicians (PCP) that can prescribe psychiatric medications, or linking them to a primary care clinic with a psychiatrist on staff that can prescribe psychiatric medications.

4. Recommended for Replication? YES

The HOPE Connections program has established itself as an important intervention for clients in SDCPH's Emergency Psychiatric and Crisis Residential Units. This peer-based model has provided several promising indicators regarding service utilization and has led to its inclusion in a current Request for Proposals (RFP). The value of this model will continue to be monitored through the end of its current contract period and as it is expanded via the new program to include many lessons learned from this process.

5. Lessons Learned in Implementation:

The following variables positively contribute to successful outcomes of HOPE Connections:

- Implementation of "warm hand-offs" wherein Community Specialists who will be working with clients post-discharge meet with patients and engage prior to their discharge from the hospital.
- Use of Community Specialists to drive patients to their initial clinic appointment immediately after discharge while ensuring that HOPE Connections establishes other transportation options and resources with them so they can maintain future appointments.
- Matching of patient with Community Specialists who have similarities in regards to culture and age.
- Increased coordination with Crisis Houses to facilitate clinic appointments.
- Increased family involvement as they also serve as an alternate source to connect with clients post-discharge.
- Considerable engagement by HOPE Connections staff with clients on the inpatient units prior to discharge.
- Coordination and communication with assigned Social Worker on the inpatient units prior to discharge.
- Positive and proactive relationships with staff at mental health clinics that includes follow up on status of clients that were referred to the clinic.
- Assigning Community Specialists to be present at clinics during walk-in hours at four different mental health clinics. This allows the Community Specialist an opportunity to set up meetings

during walk-in hours with clients that were referred to that clinic and establish relationships with clinic staff.

- Assigning clients to Community Specialists that are present during walk-in hours at the client's assigned mental health clinic to assist in the walk-in process and ensure acceptance to the clinic and provide referrals, if needed.
- Understanding the nuances of each mental health clinic site operations is vital in maximizing our assistance to clients in navigating the system. HOPE conducted research on these unique aspects and developed a spreadsheet for use with clients in successfully facilitating the timeliness of their appointments at the clinics, and to identify other activities/groups, etc. that might motivate clients to connect to their clinic.
- Informing mental health clinics of the services offered by the HOPE Connections Community RN that will assist clients with physical health problems and referrals to a primary care physician. The community RN can also assist in connecting clients that were not accepted into the Mental Health clinic to a PCP that will prescribe psychiatric medications or another clinic that has a psychiatrist.

6. **Program Cost-Effectiveness:** The program's cost effectiveness will be reviewed at the end of the project.

Next Steps/Recommendations

Based on lessons learned through this project, successful elements of the program have been incorporated into a Request for Proposals (RFP) that builds on the strengths of the peer specialist model and will now include emphasis on connecting clients to substance abuse and physical health services in addition to mental health services.

Mental Health Services Act Innovations Projects
INN-03 Physical Health Integration Project Evaluation 2013

Program Name: **Physical Health Integration Project/ICARE**
Program Start Date: **January 10, 2011**
Program End Date: **June 30, 2014**

Purpose

1. **Purpose:**
   ICARE (Integrated Care Resources) is an innovation pilot designed to create person-centered medical homes for individuals with serious mental illness (SMI) in a primary care setting.

2. **Explanation of Purpose:**
   ICARE is one of five MHSA components designed to foster new approaches to increasing knowledge about serving the mental health needs of San Diego County communities. The goals of all innovation projects are to use novel approaches to increase service access to underserved groups, increase quality of services, promote interagency collaboration and increase service access for the mental health community. The focus of the ICARE program is to enhance mental and physical wellness through a holistic and collaborative continuum of care across primary care and mental health clinics.

Learning Objectives

1. **Learning Objective (#1): Interagency Collaboration between Community Health Centers and Mental Health Providers**

What We Hoped to Learn: Whether such a transition can promote interagency collaboration between community health centers and Mental Health service providers and if it will increase access and quality of services for those individuals with acute illness who we are currently unable to be served adequately due to an overburdened Mental Health system. We hoped to see an increase in access and quality for clients with SMI.

What We Learned: The program is still ongoing but preliminary data from patients, Federally Qualified Health Centers (FQHC) and mental health clinics indicate that the interagency collaboration has increased and has promoted both access and quality. Overall satisfaction scores from clients increased by 13 percent between baseline and at 6 months, and were 3.6 percent higher when compared with the aggregate scores of other County mental health programs.

2. **Learning Objective (#2): Improvement in Overall Outcomes for Older Adult Population**

What We Hoped to Learn: Does this approach benefit and meet the mental health and physical health needs, and improves the overall outcomes of the older adult population. We hope to see an improvement in both physical health and mental health outcomes in the older adult population.

What We Learned: The program is still ongoing, but it appears as though there are very few older adults represented in the stable clinic population who meet the criteria for this project. Data from January 2013 indicates that only 12 individuals over the age of 50 were represented in the group,

accounting for less than 10 percent of the total sample. Implications for the older adult population are not immediately clear and will be reviewed in further detail when the next evaluation period begins in December 2013.

3. Learning Objective (#3): Underserved/Refugee Community Outcomes

What We Hoped to Learn: Does this approach benefit and meet the mental health needs of those in the underserved and refugee communities who typically present in primary care settings with physical complaints? We hoped to learn whether individuals who present in a primary care setting with physical health complaints, but who were actually in need of a higher level of mental health care, would be connected with mental health clinics as they were identified.

What We Learned: To date, no referrals have been made from the FQHC to the mental health clinics for refugees or any other patients. This may be because this program and the SmartCare psychiatric consultation program have provided a great deal of support to primary care to treat individuals with higher level mental health needs. It may also be because ICARE had a contractor that specifically treats mental health for refugee populations and they are not part of this project. Therefore, if refugees were identified and referred, it may have occurred outside this project.

4. Learning Objective (#4): Increase in Recognition, Referral, and/or Treatment of Poorly Served Communities

What We Hoped to Learn: If a systematic investment in the competence of primary care providers, to recognize and manage mental health needs, will increase their recognition, and referral or treatment of this otherwise poorly served community. We hoped to determine whether providing Behavioral Health Consultants (BHC) and other support staff would increase the primary care providers' ability to recognize, refer, and/or treat the SMI population.

What We Learned: Preliminary data indicate that providers feel positive about the program. *"[Providers] have enjoyed it…the opportunity to expand their skill set and also to be able to see these patients holistically…"* Data from the psychiatric consultation program (separate from this program) indicate that the clinics that participated in ICARE were some of the more frequent users of the service, which may indicate an increased awareness and willingness to serve the SMI population. Data will continue to be evaluated and reviewed to track this objective.

5. Learning Objective (#5): Improvement in Mental Health Outcomes when Clients Receive Physical Health Services

What We Hoped to Learn: Is there an improvement in mental health outcomes when clients with SMI receive ongoing physical health care services and/or treatment in a primary care setting? We hoped to see participants' scores on Illness Management and Recovery questionnaire and Recovery Markers questionnaire improve.

What We Learned: The program continues to collect data, but preliminary finding show that those participants in the project for six months showed greater mental health recovery improvements as indicated by data from the client and the BHC. This objective will continue to be tracked and evaluated as the project continues.

6. **Learning Objective (#6): Reducing Stigmatization of SMI Clients with Primary Care Physicians/Staff**

What We Hoped to Learn: If the BHC model, which has proven effective for less serious mental illness, can be adapted to assist primary care providers in serving the behavioral health needs of their patients with stable SMI. Can this role also help reduce stigmatization of SMI clients with Primary Care staff? We hoped to see a decrease in the amount of stigma experienced by the clients and to see an increased capacity on the part of the primary care providers to serve clients with stable SMI.

What We Have Learned: From baseline to the six-month follow up, clients' average stigma score decreased from 2.73 to 2.39, showing marked improvement. However, a few measures worsened including one where clients indicate that they feel they have been talked down to due to their mental health problems. We will continue to follow these measures and will combine with our key informant interview data to determine why this may be.

7. **Learning Objective (#7): Meeting the Needs of Refugee and Immigrant Populations in Primary Care Setting**

What We Hoped to Learn: If this behavioral health integrated approach meets the mental health needs of refugee and immigrant populations at the primary care setting. We hoped to learn how refugees and immigrants respond to this model of treatment.

What We Have Learned: Data that differentiate immigrants and refugees from other participants in the project are not available at this time. Staff will work with Health Services Research Center to determine whether this is possible.

8. **Learning Objective (#8): Reduction in Emergency Department Visits**

What We Hoped to Learn: If emergency department (ED) visits are reduced for individuals with SMI who are receiving ongoing physical health care compared to the current rate for clients in the Mental Health system. We hoped to see a reduction in ED visits for those with SMI who were engaged in this project.

What we have learned? Data from baseline to six months indicate that ED visits for any health reason decreased from 30.2 percent to 21.2 percent. This appears to be a significant improvement and ICARE will continue to monitor to determine whether this is maintained throughout the project.

9. **Learning Objective (#9): Transferring Clients with SMI from Mental Health Clinics to Primary Care Provider Settings**

What We Hoped to Learn: If the transfer of stable SMI clients from the health clinic into the primary care setting helps the county serve more severe SMI clients. We hoped to see an increase in access for less stable SMI clients into the County Mental Health System.

What We Have Learned: Data are still being gathered and evaluated to determine whether this project has improved access for individuals with severe SMI.

Analysis of Program Effectiveness

1. **Changes or Modifications During Implementation:**

   During the course of implementation, project staff discussed the possibility of expanding the site where the program was offered to include the south region because there were many clients in this area who would meet the criteria for participation and a health clinic was located nearby. An exam room was built at the South Bay Guidance Center to accommodate the nurses' physical exams for clients, and Family Health Centers' Chula Vista site was added to the list of participating locations for the ICARE program.

   Secondly, the staff explored the idea of utilizing the LVN as the Nurse Care Coordinator instead of an RN. It was determined that the LVN would be more cost-efficient and would provide the health information and scheduling assistance that was needed to continue to make the project successful.

2. **Impact on Participants:**

   The addition of the South region site has had a positive impact on the program and its participants. The site has become a steady source of referrals. Participants at both mental health sites are now able to choose to receive their healthcare at Family Health Centers, Chula Vista if that location better meets their needs. Other choices include Logan Heights, North Park and the Downtown clinics. The clients who now have access to this program receive all of the services available for the ICARE participants at the Areta Crowell Center: physical health screenings and on-site scheduling assistance; substance abuse screening and counseling; peer assistance in transitioning to the Family Health Centers' services; and support from BHCs during the process.

3. **What Was Learned:**

   In addition to providing services in an area where the ICARE program was clearly needed, the ICARE expansion showed us how participants in different regions respond to the model. Staff found that while clients from Areta Crowell, who are a more transient population, were relatively amenable to the idea of needing to access their mental and physical health care at a new location, the clients in Chula Vista were more resistant. Staff noted that there is a much higher population of Latino clients in South Bay; they value a sense of family with the staff and with other clients. The idea of transferring to another location was challenging for many of these clients.

   To meet this challenge, BHCs began to spend more time at the mental health site so that clients would meet them and get to know them better before they would be asked to transition to the health clinic for their services. Because this relationship was built on the front end, clients were then greeted by a familiar face when they made their first appointment at the new clinic. The BHCs provided the clients with more detail regarding the building and the process at the new clinic, which made the transition smoother.

4. **Recommended for Replication? YES**

   Yes, this project is recommended for replication. While the program could be run successfully as is, the County has chosen to use elements from this program in combination with other projects to create a new program.

5. **Lessons Learned in Implementation:**

   The program is set to end June 30, 2014. In addition to the lessons learned above, we will have data regarding health indicators for the project participants available after program completion.

6. **Program Cost-Effectiveness:**
   There was an increase in services because the funding provided additional services that were previously unavailable. ICARE supplies a Nurse Care Coordinator onsite at the mental health clinic that performs physical health screenings and direct appointment scheduling at FHC. An Alcohol and Other Drugs (AOD) counselor is also available for screenings, groups, and follow-up support. Peers help transition clients to the new health center, provide follow-up with clients regarding appointments and also help clients obtain necessary eligibility paperwork. BHCs provide necessary, therapeutic support as client's transition from the mental health clinics to the FHC sites.

Next Steps/Recommendations

Program to be modified and continued within system of care with alternate funding source, to be determined.

Mental Health Services Act Innovations Projects
INN-04 Mobility Management in North San Diego County Evaluation 2013

Program Name: **North County Transit District: Mobility Management Program**
Program Start Date**: August 1, 2011**
Program End Date: **June 30, 2014**

Purpose

1. **Purpose:**
   Increase access to underserved groups. The Mobility Management Program (MMP) is a peer-based transportation program designed to improve the availability, quality and efficient delivery of transportation services as well as increase participant access to services and activities. It is also meant to minimize barriers to transportation for seniors, people with disabilities, and low-income residents in North County. The primary components of the program include travel training and transportation coordination.

   Transportation Coordinator
   Transportation Coordinators educate service providers and consumers on transportation resources in the North San Diego County region. Mental health consumers who preferred to receive training in a group format were able to participate in group travel training courses facilitated by the Transportation Coordinator. Similarly to the one-on-one mentoring provided via a Travel Trainer, group classes focus on educating consumers on how to navigate the transit system safely and confidently throughout the local community. Consumers learn how to use the Rider's Guide to map routes to and from their desired destinations, transit fares using the ticket vending machines, safety, problem solving, on-line resources, transit center locations and amenities, and more. The final component of the group training process included planning and implementing a field trip, by utilizing public transportation, to a location selected by the class members.

   The Transportation Coordinator also assisted in problem solving various transportation needs consumers or service providers may encounter. Consumers with unique transportation needs due to language barriers, geographic barriers and age, were assisted to develop customized transportation strategies.

2. **Explanation of Purpose:**
   It is a well-established fact that current systems of transportation in San Diego County do not meet the needs of the people who must rely on public transit or private transportation (Full Access & Coordinated Transportation, Inc.). Numerous stakeholders have expressed this need throughout the MHSA Community Planning Process.

   Stakeholders stated that a peer-based transportation program could “increase self-sufficiency,” provide “more access to patient services”, and lead to “a lot less appointments missed”. Other benefits that the stakeholders identified were the opportunity to “build relationships with peers while sharing rides”, the reduction of “family’s stress because they will know that transportation assistance is available”, and the reduction of “isolation because clients will need to get out and talk with peers in order to get to their appointments”.

Studies clearly demonstrate that older adults are underserved by community mental health systems for a number of reasons. One significant cause is the inability for individuals to access adequate services. In addition, changes in regional demographics and land use patterns require new approaches for providing transportation services, particularly for underserved adults and older adults in North San Diego County. North San Diego County consists of a geographic region larger than the state of Rhode Island, and over half of the area is rural. Historically, due to low population numbers, these areas consistently struggle with securing adequate resources to provide comprehensive health and social services to community residents.

According to findings of the study, "Transportation Concerns and Needs of Mental Health Client Populations in North San Diego County" (A-Menninger-Mayeda-Alternative Transit Planning), residents have limited knowledge of available transportation resources. Evidence suggests that some consumers are reaching out and effectively connecting with public transit options; however, it is not the majority.

Transportation plays a critical role in providing access to employment, health care, education, community services, and activities necessary for daily living. The importance is underscored by the variety of transportation programs created in conjunction with health and human services programs and the significant federal investment in accessible public transportation systems, United We Ride.

Learning Objectives

1. Learning Objective (#1): Utilizing Transit

What We Hoped to Learn: With the skills and confidence gained by participating in the MMP, participants will utilize transit more frequently, relying less upon family and friends. By reducing various barriers to utilizing public transportation, participants will become more confident and independent, thus improving their overall social functioning and satisfaction.

What We Learned:

- 70 percent (75 of 107) of travel trainees reported utilizing transit more often than they did prior to participating in the travel training program.
- 58 percent (68 of 116) reported receiving rides less frequently from friends/family for the purpose of attending appointments/activities.

2. Learning Objective (#2): Scheduling and Attending Health/Medical Appointments

What We Hoped to Learn: With the ability to comfortably utilize the transit system, participants will be more apt to schedule and attend health and medical appointments. When consumers/participants are comfortable with their mode of transportation, they are more likely to schedule and attend events in the community, including appointments related to health and healthy living, which will enhance the participants' overall health and well-being.

What We Learned:

- 69 percent of participants (63 of 91) who reported on the pre-test that they avoided scheduling health/medical appointments due to transportation barriers reported an increase in the number of appointments they now schedule.
- 77 percent of participants (67 of 87) who reported on the pre-test the inability to attend health/medical appointments due to transportation barriers reported an increase in the number of appointments they now attend.
- 83 percent of consumers (89 of 107) who completed travel training reported on the post-test that they use public transit to participate in social activities.

3. Learning Objective (#3): Outcomes for Peer Volunteers and Participants

What We Hoped to Learn: By recruiting peers as volunteer drivers for the Ride Share component of the program, both the volunteer and participant would enhance their social skills, the participant would experience increased mobility, and the family members would be allowed some respite from the responsibility of transporting the participant. The objective of the Ride Share program was to reduce barriers and increase mobility for the targeted population. Some of the expected benefits that derived from ride sharing would include increased mobility for the rider, an opportunity for both the volunteer driver and the rider to enhance existing social skills, relieve family members of the responsibility of transporting their loved ones, and provide an added degree of safety/security for the rider. Ride sharing could be used to attend social events, receive medical and mental health services and/or participate in leisurely activities such as shopping and recreational activities, which may otherwise go unattended.

What We Learned:

- Though well received and desired, the Ride Share component was discontinued for the following reasons:
  - Difficulty recruiting a sufficient number of volunteer drivers. The potential liability for the driver was also a deterrent.
  - Most consumers preferred the advantages of Ride Share services over using transit, even if they possessed transit skills, which was perceived by the program as something not sustainable due to lack of volunteer drivers.
  - Information provided by applicants' references was not always reliable.
  - High administrative requirements were necessary to provide services responsibly and safely.

Analysis of Program Effectiveness

1. Changes or Modifications During Implementation:

The Ride Share component was discontinued.

2. Impact on Participants:

Those who were receiving rides no longer had that option available. All other components remained.

3. **What Was Learned:**

What Worked:

- 463 individuals engaged in services which exceeds the contract goal.
- Developed and strengthened partnerships with Clubhouses, hospitals and many of the mental health provider agencies.
- The benefits gained by the volunteers (social connection, sense of worth and independence) were evident in participants.
- Offering incentives to encourage program participation (compass cards, transit passes, gift cards, etc.).
- Consumers developed social relationships with one another as a result of program participation.
- Consumer engagement increased access to services and activities; and program volunteers were very committed. Several consumers were very active in encouraging their peers to enroll.
- Providing group travel training services.
- Marketing on the BREEZE Buses (Bus Placards).
- Peer-based service model.

Challenges Faced:

- Difficulty recruiting a sufficient number of volunteer drivers. The potential liability for the driver was also a deterrent.
- Most consumers preferred the advantages of Ride Share services over using transit, even if they possessed transit skills.
- Information provided by applicants' references was not always reliable.
- High administrative requirements needed to provide services responsibly and safely.
- Most mental health service providers have heavy workloads. This makes it difficult for many of them to dedicate time/effort needed to facilitate consumer access to the MMP.
- Private practitioners were difficult to engage.
- The stigma associated with mental illness was a barrier to enrollment for many, particularly older adults.
- Consumers were not able to readily identify "recovery skills".
- Transportation options in rural communities are very limited.

4. **Recommended for Replication? NO**

While the program has had some success with some mental health clients, it is not recommended for replication due to its low priority for the limited funding resources available. Transportation issues in the North County Regions, particularly in the rural areas and for adults with mobility issues, cannot be significantly improved by this program.

5. **Lessons Learned in Implementation:**

Lessons learned are detailed below each Learning Objective in the above narrative.

6. **Program Cost-Effectiveness:**

   There was an increase in the number of participants who were able to utilize the transit system to increase both social and health-related interactions. This program utilized Volunteer Travel Trainers and volunteer drivers, which improved the cost-effectiveness of the program.

Next Steps/Recommendations

Program to be discontinued; however, effective elements to be incorporated into existing programs.

Mental Health Services Act Innovations Projects
INN-05 Positive Parenting for Men in Recovery Evaluation 2013

Program Name: **Positive Parenting for Men in Recovery**
Program Start Date: **July 1, 2010**
Program End Date: **June 30, 2013**

Purpose

1. **Purpose:**
   A 13-session group program with four objectives:
   i. Increase Positive Parenting skills and model with children
   ii. Improve Mental Health Wellness
   iii. Reduce substance abuse risk factors and/or stressors
   iv. Reduce/prevent violence and trauma (directed at children or self and others)

2. **Explanation of Purpose:**
   This was a voluntary group program for men in the following target population:
   i. Transition age youth (TAY) , ages 18-25
   ii. Enrolled in non-residential AOD treatment programs at six Regional Recovery Centers (RRCs)

   Six Regional Recovery Centers had equal funding and objectives, noted in the table below:

Contract	Contractor	RRC	3-Year Funding	3=Year Caseload Objective	Documented Graduates	Pre- and Post-Tests	Surveys	Comments
534111	MITE	SOUTH	$105,000	75	16	8	17	SPECIFIC KNOWLEDGE INCREASE NOT REPORTED
534112	MITE	EAST	$105,000	75	41	20	27	SPECIFIC KNOWLEDGE INCREASE NOT REPORTED
534113	MHS Inc.	CENTRAL	$105,000	75	66	51	0	SPECIFIC KNOWLEDGE INCREASE NOT REPORTED
534154	MHS Inc.	NORTH INLAND	$105,000	75	17	0	0	SPECIFIC KNOWLEDGE INCREASE NOT REPORTED
534155	MHS Inc.	MID-COAST	$105,000	75	0	35	24	REPORTED 32% AVERAGE INCREASE IN POST-TEST SCORES
534156	MITE	NORTH COASTAL	$105,000	75	49	23	0	SPECIFIC KNOWLEDGE INCREASE NOT REPORTED
TOTALS			$630,000	450	189	137	68	

Learning Objectives

1. Learning Objective (#1): Increase Positive Parenting Skills

What We Hoped to Learn: These groups would produce measureable improvement in positive parenting skills as measured by pre- vs. post-test improvement.

What We Learned: Non-clinical therapy in a relaxed group setting, incorporating approved parenting curriculum and led by experienced clinicians, may be helpful in improving parenting skills for a minority percentage of motivated or court-ordered clients, including those already receiving mental health services. Pre- vs. post-test improvement was not measured formally in all cases.

2. Learning Objective (#2): Improve Mental Health Wellness

What We Hoped to Learn: This program component was a voluntary counseling/education opportunity for male clients to learn more about mental health wellness and additional treatment resources as well as child and family trauma/violence prevention issues.

What We Learned:

- A relaxed "non-clinical" tone or setting allowed the participants the time and encouragement to engage in the group, bond with other members, be open in a safe place, and be receptive to the instructor and curriculum.
- Topics included mental health resources in the community, self-monitoring and awareness for signs of mental health problems, and where to go for medication management support.
- Providing refreshments (snacks and soft drinks) for the male TAY population is highly recommended to encourage participation and retention.

3. Learning Objective (#3): Reducing Substance Abuse Risk Factors and/or Stressors

What We Hoped to Learn: This program component would help clients identify life stressors related to parenting issues and provide additional tools for reducing risk factors for relapse and inadequate or inappropriate parenting, while supporting the primary substance abuse treatment.

What We Learned: As tools, effective approaches for this population include:

- Redirection of anger by acknowledgment and adoption of positive parenting behaviors which are "best for the child".
- Meditation and visualization techniques were taught as stress reduction tools.
- Clients in the SBRRC who benefitted from the group chose to continue the group outside the contract setting, and were to be joined by the instructor.

4. Learning Objective (#4): Violence and Trauma Prevention

What We Hoped to Learn: Contractor's use of "trauma-informed" approaches would recognize the vulnerabilities of trauma survivors, including these male adult clients, and avoid inadvertently re-traumatizing clients, while also facilitating client participation in treatment.

What We Learned

- A large majority of TAY fathers in AOD programs (clients) have experienced some form of trauma, neglect and/or abuse as children.
- Clients benefited from increased knowledge about trauma and how it impacts negative and positive approaches to parenting.
- Role play and discussion of modeling healthy parenting was perceived as being beneficial to most clients in a group setting.

Analysis of Program Effectiveness

1. **Changes or Modifications During Implementation:**

   None

2. **Impact on Participants:**

   Of 189 documented program graduates:
   - 68 clients completed satisfaction surveys.
     - 70 percent of surveys were rated positively.
   - 137 clients completed both the pre-and post-program tests.
     - An average of 49 percent of post-tests showed improvement, below the benchmark expected outcome of 70 percent discussed with providers.

3. **What Was Learned:**

   - Creating age-based parenting sub-groups with some level of shared experience fosters comfort and openness in clients.
   - Sub-groups of differing perspectives and cultural backgrounds can learn improved parenting skills from each other by dialogue in the group setting and sharing successful strategies.
   - Improving parenting skills appears anecdotally to promote increased sobriety and social competence of formerly substance-abusing, male parents.

4. **Recommended for Replication? NO**

   The cost per client was a main contributing factor to discontinuing the program; however, components and aspects of this model can be incorporated into existing AOD services or Prevention and Early Intervention programs with similar benefits to the client population and their children.

5. **Lessons Learned in Implementation:**

   - Positive parenting resources for men in AOD treatment are in a supply deficit. This target population will benefit from the curriculum ["A Nurturing Father's Journal" Developing Attitudes and Skills for Male Nurturance Workbook. Mark Perlman, MA 1998] in group sessions, within established contracts and using existing staff.
   - Providing separate, non-treatment oriented parenting groups allows clients to focus on parenting skills taught by the instructor and curriculum, yet supports AOD treatment goals.
   - Providing snacks and soft drinks for the male TAY group is highly recommended to increase participation and retention.

- It is recommended that TAY treatment participants be screened to see whether they need anger management services as a companion to substance abuse treatment.

6. Program Cost Effectiveness:

630,000-dollar budget total per 189 graduates = 3,807 dollars per person at budget, but actual cost was less due to some contractor underspending. There was an increase in level of services as these services formerly did not exist. The staff-to client ratio was 1:7.

Next Steps/Recommendations

Program to be discontinued; however, effective elements to be incorporated into existing programs.

Mental Health Services Act Innovations Projects
INN-06 After-School Inclusion Program Evaluation 2013

Program Name: **MHSA Innovations After-School Inclusion Program**
Program Start Date: **July 1, 2012**
Program End Date: **June 30, 2015**

Purpose

1. **Purpose:**
   The purpose of the MHSA Innovations After-School Inclusion Program is to increase access to after-school programs for youth with social-emotional/behavioral issues. The program provides opportunities for students, previously stigmatized and/or precluded from participating, to be integrated with their peers by utilizing Inclusion Aides to provide behavioral support and teach them pro-social and functional skills. The program introduces to the behavioral health system a community defined approach that has been successful in a non-mental health context. Additionally, the Inclusion Program educates after-school staff, families, and other community members on how to help youth with behavioral issues thrive in their environment with the intent of building in sustainability of concepts in after school programs. The Inclusion Program measures the impact of the benefit derived from behavior interventions and access to after-school programs on youth with behavioral issues and their families with the goal of leading happier, healthier, less stigmatized lives and the potential to reduce need for future behavioral health services.

2. **Explanation of Purpose:**
   Research has shown a need in the community for services that provide interventions for youth who are exhibiting social-emotional/behavioral issues while in the care of after-school providers who are not equipped with the knowledge and/or training to work with these youth. Therefore, these youth are at risk of being precluded or discharged from the after-school program. When youth do not have the opportunity to participate in after-school programming, stressors may occur in the family which can lead to further issues in the community. Often, families do not have the resources and/or knowledge to access available services for their children. Inclusion Program staff that are working with these youth are able to provide appropriate support aligning with the behavioral health system in a nontraditional mental health setting. Inclusion Program staff offer one staff-per-client behavioral support to the youth and teach the after-school staff how to work with these youth through both formal and informal training.

Learning Objectives

1. **Learning Objective (#1): Through behavior intervention, the Inclusion Program will be able to provide improvements in students' self-esteem, social competence, and healthy behavior.**

What We Hoped to Learn: Inclusion Aides are able to assess each referral and identify the problematic behaviors that are precluding the participant from fully participating in the after-school program. Inclusion Aide would be able to distinguish between self-esteem, social competence, and healthy behaviors in order to accurately assess each behavior and what it correlates with. Program

would be able to see a positive change in each of the three areas: self-esteem, social competence, and healthy behavior.

What We Learned: Participants' behavior issues stem from mental health issues, environmental stressors, trauma, educational difficulties, etc. The program may see a positive change in one area, (e.g., self-esteem), but not in all three areas at once, and/or the participant may only struggle in one area. Inclusion aides prioritize the area of need and due to the limited time for services the participants' plan may only focus on one area of need. The participants' behaviors may be reflective of causes that are not measured through self-esteem, social competence, and/or healthy behavior. The program learned that with the difficult and complex issues that our participants face, there is a benefit for on-going system support.

2. **Learning Objective (#2): Inclusion Program participants will increase their social connectedness and will live happier, healthier, less stigmatized lives while experiencing success and normalcy.**

What We Hoped to Learn: Inclusion Program participants will be included and will participate in the after-school program with the same success and normalcy as all after-school program participants. Participants will not be excluded from certain activities or stigmatized for limitations. Participants will be successful and learn ways in which they can manage their own behavior in the context of the program. Participants will carry this success on through all areas of their life.

What We Learned: Inclusion Program participants are able to be integrated into their peer group with the right tools and interventions provided by the Inclusion Aide as well as the after-school program staff. Success in the program is not only measured by the success of the participant, but the success of the after-school staff and their ability to understand the behaviors and effectively implement interventions. Inclusion has learned that each participant is different and success may look different for each one of them, requiring individualized services. A small improvement in one area may have a significant impact on the participants' self-esteem and/or behavior. This improvement can help the participants integrate into their peer group with more success. Inclusion has learned that interventions provided by Inclusion Aides in the after-school program are often helpful in the classroom as well, and teachers are open to implementing different strategies when able.

3. **Learning Objective (#3): Parents/Guardians will be satisfied with the services provided for their youth and their stress level will decrease.**

What We Hoped to Learn: Parents will receive fewer phone calls from the after-school program and/or teachers regarding their child's behavior. Parents will decrease their stress level and learn how to implement interventions to help their child in the home. Parents will take all the information and resources given to them and put them into place for both the participant and family. Parents will participate in services with the Inclusion program on a consistent/regular basis. Parents will recommend the Inclusion Program to other parents that face similar struggles with their children.

What We Learned: Parents are extremely busy and have many demands for their time. Parents are interested in the program but do not always have the time needed to implement interventions for their children in the home. The program has learned that measuring stress is complex. Parent stress

level is based on a number of things going on in their life; therefore, the way a parent measures stress can be very different on any given day. Parent stress level can have a high correlation to a child's behavior, but it also may have a low correlation to the behavior.

Parents often have different definitions of stress and base stress on several different factors. Parents are limited with their resources and do not always qualify for the most appropriate services and/or have the time to connect with community resources. However, we have learned that many parents go the extra mile for their child and are willing to help in any way they are able to.

We have learned through Parent Advisory Group meetings that Inclusion Aide services work, and parents are pleased with the improvements that they see in their child. Parents would like to see services run longer and follow their children to different schools.

4. **Learning Objective (#4): Gatekeepers will increase awareness of how to identify and work with at-risk youth and refer them to appropriate services.**

What We Hoped to Learn: After-school program staff will embrace the Inclusion Program model. After-school program staff will take the interventions and strategies provided by the Inclusion Aides and continue to implement them after the participant is discharged from the Inclusion Program. After-school staff will understand the causes of different types of behaviors and issues the participants face. After-school staff will have an increased awareness of how to identify what factors play into the behavior. After-school staff will obtain the knowledge needed to identify and work with these participants on their own, and, ultimately, the after-school program would be better positioned to support youth with social-emotional and behavioral challenges.

What We Learned: The Inclusion Program has learned that there is a constant turnover rate with after-school staff, which makes sustainability of program knowledge challenging. After-school staff often view Inclusion Aides as the "fixers" and, therefore, do not try to implement interventions on their own. After-school staff are open to training and learning about behaviors but are consumed with the large ratio of youth they are working with so they often do not have the time needed for these particular participants. Inclusion has learned that some after-school programs are more open to interventions offered by Inclusion Aides than others. The Inclusion Program (Inclusion) also learned that there are site supervisors and staff that utilize all the interventions and strategies given to them by Inclusion Aides. These after-school program sites and staff have more participant success and less behavior issues.

5. **Learning Objective (#5): All program participants are evaluated and referred to external services, as needed.**

What We Hoped to Learn: All program participants and families that are in need of external resources will be successfully connected to community resources.

What We Learned: Not all families are interested in receiving information about other programs and services at the time of intake. Many families are in need of extra resources, but may feel ashamed to ask. Often times there are services our participants may need but do not have access to due to lack of transportation and/or income. Inclusion has learned that Inclusion Aides often have more success with providing referrals during the course of services rather than at the beginning or end. There are

families that have taken advantage of the external resource given to them. When families are able to connect with resources and outside referrals, we tend to see more change within the family system.

Analysis of Program Effectiveness

1. **Changes or Modifications During Implementation:**
   During the course of the programs first year, Inclusion has made modifications programmatically, administratively, and fiscally.

   Programmatic changes:
   Inclusion has had several changes in staff due to a high rate of turnover. Over the course of the program, staff members were obtaining high qualifications in order to work with this population of youth and, therefore, are now looking to obtain full-time positions in which they can grow.

   Inclusion developed standardized training curriculums on a wide variety of topics that fit the need of the after-school program and participant issues. We changed our delivery model and decided to implement these standardized trainings quarterly at after-school program staff meetings. Inclusion has also implemented training at camp site facilities, while providing support for participants at camp.

   Inclusion set standards for productivity, such as requiring Inclusion Aides to meet with after-school staff for at least 30 minutes per week, meeting with school staff monthly, working with participants at a high rate, and meeting with families regularly.

   Inclusion continues to work with participants for three months, but has broken it down to 60 school days so holidays do not play into a decrease in service time.

   Full-time program staff meet regularly with the branch coordinators and directors to discuss program challenges and successes.

   Inclusion has added an additional component of supervision where the Lead Inclusion Aides provide individual and group supervision as well as go out and monitor school sites.

   Inclusion increased the number of training opportunities given to the Inclusion Aides, including but not limited to:
   - Yoga in the Raw
   - Behavior Management 101
   - Positive discipline

   Inclusion Aides were given the opportunity to pick one to two trainings to attend that were specific to issues at their site and the participants' behaviors.

   Inclusion purchased additional supplies that were put into the KITS and specific to certain school sites and participant needs.

   Administrative Changes:
   Inclusion hired a 5th Lead Inclusion Aide to help facilitate the training process and develop training curricula, as well as monitor school sites. Inclusion hired an Advocacy Coordinator to help with community outreach, recruitment, and program development.

Fiscal Changes:
Fifteen additional Inclusion Aides, two Data Entry staff and one Receptionist were added to the program's staff on a temporary basis.

The program Research Associate started as a part-time position then was able to become full-time for the remainder of the fiscal year. Beginning July 1, 2013, the position went back to part-time and as of October, has been eliminated and replaced with an Independent Subcontractor for the outcome analysis.

Inclusion is contracting with Harder & Company to do data analysis.

The program Office Administrator started as a 30-hour/week position and is now a full-time position.

Inclusion changed our expectations in staff travel mileage as the program requires more travel than expected.

2. Impact on Participants:

Inclusion has been able to implement a positive change model for working with youth. We have effectively enhanced staff's ability to deliver services to participants and their families.

3. What Was Learned:

During the implementation of the program's first year, Inclusion learned the following:

- It is critical to consistently reach out to school districts to ensure collaboration.
- Having a tiered system of supervision is important. Lead Inclusion Aides provide a wealth of knowledge and guidance to Inclusion Aides in their region.
- The addition of a 5th Lead Inclusion Aide helped improve program development and sustainability.
- The best way to train the after-school staff is to have standardized training curricula that can be used across the county to educate staff on a wide range of topics and behaviors.
- There are different types of after-school programs, such as non-licensed programs (free) vs. licensed programs (parents pay for services). There are different regulations and requirements for each program.
- It is integral for Inclusion to have constant communication with the YMCA branches to ensure collaboration and increased referral numbers.
- It takes not only a large amount of money, but a large amount of time, effort, collaboration, drive, and passion to set up the infrastructure of a brand new program, as well.
- Staff is attracted to the Inclusion Aide position as a stepping stone to other professions within the field of mental/behavioral health. Part-time staff report that this program provides exceptional training, guidance, support, and supervision; however, the need for them to obtain a full-time position outweighs their experience with the Inclusion program. Having the ability to retain staff and keep continuity within the after-school program would make the program more effective. It takes an immense amount of time to train new staff coming in at such a high rate.
- It is harder to find bilingual staff.
- In order to produce quality data, a specialized evaluator and system is critical.

- Inclusion learned through trauma-informed care that the majority of our participants have mental health issues and/or experience trauma in some way. More participants than the program originally thought have been or are involved with the child welfare system, are exposed to substance abuse, have or have had incarcerated parents, and exhibit different mental health diagnosis.
- Many of our participants come from single-parent households and/or are being raised by a relative or guardian.

4. Recommended for Replication? YES

Explain:
The Inclusion Program has been very successful throughout its first year. Inclusion has learned what our limitations, challenges, and capabilities are. The biggest difficulty for the program has been sustaining staff for part-time positions. Staff has the qualifications and is looking for full-time work. For the continuity and stability of the program, it would be helpful to have the Inclusion Aide position be full-time, but due to after-school program hours, having full-time Aide positions is not practical or cost-effective.

5. Lessons Learned in Implementation:

While implementing the Inclusion Program we have learned about all the available resources in the community, and the best practices for reaching out and linking participants and families to appropriate services and resources.

Inclusion has learned that staff consistency is very important and integral to the success of the youth and families.

Inclusion has learned that youth are in the after school program until 6:00 p.m., Monday through Friday, and on the weekend parents don't have resources to get the participants involved in recreational activities and sports. Sports are not offered in all after-school programs.

Inclusion has learned that not all after-school programs and/or districts are run the same; therefore, it is hard to make staff aware of all the differences and hold them accountable to the same standards.

Inclusion has learned that the background and experience level within the after-school staff is very different and often limited.

6. Program Cost-Effectiveness:

Throughout the first year of programming, there was an increase in the amount of schools and participants. Inclusion was able to provide service due to the budget and ability to hire 15 additional Inclusion Aides on a temporary basis. This gave Inclusion the capability of working with more participants, families, and training more after-school staff.

Actual cost per client for the fiscal year 2012-2013 was 4,700 dollars; however, this was during the start-up year, and traditionally program's cost per client is higher during start-up periods.

This compares to an estimated target cost per client of 3,000 dollars in the Children's outpatient system; however, the premise is that if you can do preventive work on the front end, there are savings not only in dollar terms, but also in the long-term impact of preventing youth from

entering the behavioral health system. Youth who have higher mental health needs can exceed costs of 10,000 dollars per year if they need ancillary or day program services.

A potential one-staff-per-client behavior coaching service comparison could be made with Therapeutic Behavioral Services, which has an average cost per client of 5,000 dollars.

Next Steps/Recommendations

Yet to be determined as the program began July 1, 2012, so only the first year data of a three-year contract is available.

Mental Health Services Act Innovations Projects
INN-07 Transition Age and Foster Care Evaluation 2013

Program Name: **TAY Academy**
Program Start Date: **July 10, 2012**
Program End Date: **June 30, 2015**

Purpose

1. **Purpose:**
   a. Increase access to underserved groups by:
      - Providing solutions to the challenges, problems, and barriers identified by the community for Transition Age Youth (TAY) and Foster Youth.
      - Establishing five regionally-based TAY Academy Centers that integrate coaching, mentoring and teaching strategies resulting in a successful transition to independent living and an increase in the number of youth/TAY who transition out of the Children's and Adult Behavioral Health Systems of Care.

2. **Explanation of Purpose:**
   a. TAY and a prominent subset of current and former Foster Youth often have difficulty in transitioning from the Children's to the Adult System of Care and often struggle with a lack of overall support and access to care. Subsequently, these TAY are at an elevated risk for mental illness compared to their same age peers.

Learning Objectives

1. **Learning Objective (#1): Individualized goals and activity modules that address goals and reduce the problems and barriers, including:**

   a. TAY lacking self-identity, sense of purpose, and passion for future:
      - 144 out of 818 youth (18 percent) who received services, created individualized vision plans to address their needs/goals and reduce their problems and barriers. Connections coaches and Youth Support Partners YSP then assisted youth in making community connections and accessing resources. Examples include: transport to appointments and teaching them to use public transportation; navigating applying for resources; developing stress tolerance skills and healthy/safe coping skills; linkage to resources and appointments for housing, education, and employment; and assisting youth in developing skills to maintain stability.
      - 21 of the 144 youth (15percent) demonstrated intensive engagement for a period of at least six months by accessing Connections coaching and Seeking Safety curricula, vocational training, and/or short-term stabilization housing.

   b. Foster/at-risk non-engaged TAY are at an elevated risk for mental illness compared to their age peers:
      - 18 youth out of 100 (18percent) showed improvement in areas that support reduced engagement in the Children or Adult Mental Health Systems of Care such as: Self Care behaviors, Healthy Development, Protective Mechanisms and Resiliency.

- 18 youth out of 100 (18percent) showed improvement in five relational competency areas including empathy, social conduct, expression of emotion, impulse control, and insight.

c. TAY do not effectively engage in available resources:

- 29 youth out of 150 (19percent) demonstrated sustained or increased productivity by enrollment in school, college, training program, community service program or employment.
- 18 youth out of 100 (18percent) showed improvement in five relational areas that support reduced engagement in the Children or Adult Mental Health Systems of Care such as: Self Care Behaviors, Healthy Development, Protective Mechanisms and Resiliency.

d. There is a lack of coaching, mentoring and teaching TAY on identifying goals that directly connect to their passion and motivators:
- 52 youth out of 150 (35percent) demonstrated progress towards meeting one or more life plan goals in the areas of Safety, Health and Wellness, Education, Employment, Self-Sufficiency, and Stability.
- 21 youth out of 100 (21percent) demonstrated intensive engagement for a period of at least six months who accessed connection coaching and either Seeking Safety curricula, vocational training, and/or short-term stabilization housing.
- While required to engage a minimum of 40 youth, 168 youth participated in leadership and development activities.
- 1,424 duplicated youth attended skill-development workshops, classes, or support groups at the TAY Academy Centers.

e. There are insufficient support resources for at-risk, non-engaged youth and foster TAY:
- 29 youth out of 150 (19 percent) demonstrated sustained or increased productivity by enrollment in school, college, training programs, community-service programs, or employment.
- 18 youth out of 100 (18 percent) youth showed improvement in five relational areas that support reduced engagement in the Children or Adult Mental Health Systems of Care such as: Self Care Behaviors, Healthy Development, Protective Mechanisms and Resiliency.

2. Learning Objective (#2): We sought out to learn whether this type of community integration program improves TAY outcomes by:

a. Increasing the engagement and retention rates of foster youth in supportive transitional activities:
- 75 former foster youth created vision plans, accessed connection coaching, and increased their engagement in supportive transitional activities. (Creating vision plans is a requirement of the Statement of Work (SOW), although there was no minimum expectation.)
- 34 out of 818 (4 percent) of youth were current or transitioning foster youth from the foster care system.

b. Assisting TAY in developing goals and life plans; reducing the number of youth/TAY that would need to transition to Adult specialty mental health services:
   - 96 TAY Academy youth, per SOW, were to be assisted in developing life plans that may have reduced the number of TAY that would transition into adult mental health services. (This number is out of the total number of youth who accessed Connections Coaching who demonstrated needs for vision planning, and had their needs met through Connections Coaching and did not require additional referral to the Behavioral Health System of Care.)
   - 52 youth out of 150 (35 percent) demonstrated progress towards meeting one or more life plan goals in the areas of Safety, Health and Wellness, Education, Employment, Self-Sufficiency, and Stability.
   - 18 youth out of 100 (18 percent) showed improvement in areas that support reduced engagement in the Children or Adult Mental Health Systems of Care such as: Self Care Behaviors, Healthy Development, Protective Mechanisms and Resiliency.

c. Increasing the number of youth/TAY who transition out of the Children's and Adult Systems of Care that participate in transitional activities:
   - TAY Academy reported that 18 out of 21 (86 percent) of youth, who engaged for at least six months with a Connections Coach, showed improvements in areas that support reduced engagement in the Children's or Adult Mental Health System of Care, including Self Care Behaviors, Healthy Development, Protective Mechanisms and Resiliency.

d. Providing the support that TAY need to navigate resources; increasing youth/TAY participation in school and/or employment:
   - 29 youth out of 150 (19 percent) demonstrated sustained or increased productivity by enrollment in school, college, training program, community service program or employment.
   - 24 youth out of 50 (48 percent) were accepted into the Eco-Eventerprise or NAVSUP Programs. Of the 24 youth, nine (38 percent) completed initial training for Eco-Eventerprise or NAVSUP. No youth were employed after six months, including employment by Eco-Eventerprise or NAVSUP.
   - 27 youth out of 75 (36 percent) received vocational training, including those participating in Eco-Eventerprise and NAVSUP.

e. Reducing rehospitalizations, legal system involvement, incarceration and homelessness (same as above):
   - 5 youth out of 100 (5percent) who had prior legal system involvement demonstrated reduced criminal activity.
   - 30 youth out of 30 (100 percent) received stabilization housing directly through TAY Academy contractor or subcontractors.
   - 91 youth obtained housing other than TAY Academy stabilization housing.

f. Increasing healthy behaviors:
   - 28 youth were connected to a medical home and received medical check-ups and/or physicals. In addition, numerous youth engaged in classes, groups or programming that actively engaged youth, thus increasing healthy behaviors.
   - Healthy behaviors can be documented in acquisition of housing, employment, and through participating in leadership.

- Housing –91 youth.
- Employment –27 youth out of 75 (36 percent) received vocational training.
- Leadership –168 youth, while only 40 were required, participated in leadership and youth development activities.

Analysis of Program Effectiveness

1. **Changes or Modifications during Implementation:**
   The program did not expend their full start-up budget, and, as a result, funding was reduced during the first fiscal year in the amount of 207,607 dollars. This changed the program's annual contract amount from 1,812,706 dollars to 1,605,029 dollars.

2. **Impact on Participants:**
   The youth who were surveyed noted that they strongly agreed or agreed with the statement "TAY Academy staff understands how to work with youth". Youth were heard, respected and valued, were involved in making decisions about activities, felt free to share their opinions and ideas about the Academy with staff, and there was a culture of acceptance for differences at the TAY Academy.

3. **What Was Learned**:
   - Current and former foster youth gained support through the Extended Foster Care (AB 12) Units (HHSA Child Welfare).
   - Leading from behind and allowing the youth to be the experts of their own experience was successful.
   - The drop-in model appears to not lend itself to support a consistent engagement and sustained impact over time. The model does not have the capability to track the TAY life goals/needs and long-term well-being.

   Year 2: Fiscal Year 2013-2014
   - Reduce transitional housing funding by 50 percent due to decreased utilization.
   - Redirect Eco-Eventerprise (vocational training) component to another model (to be determined).
   - Consolidate sites.
   - Change service delivery model to more effectively engage Extended Foster Care (EFC) youth.
   - Ensure that the tracking system is gathering needed learning information and/or contract with another evaluator.

4. **Recommended for Replication? YES**

   This program structure has been successful for engaging homeless TAY for a short period of time. The recommendation would be to replicate the program with the addition of a housing support specialist to effectively link homeless youth to housing and community resources over a longer period of time to track effectiveness. In addition, the recommendation is to provide services that target high risk EFC youth, to prevent homelessness, and a successful transition to adulthood.

5. **Lessons Learned in Implementation:**

   a. Housing was a barrier and did not get implemented until four months into the program. Issues included:
      - Gaining acceptance from the renting agency.
      - Identifying youth.
      - Difficulty in monitoring housing.
      - Housing utilization rate was approximately 53 percent.

   b. The employment component (Eco-Eventerprise) experienced several unanticipated challenges:
      - Youth could not access the training/classes due to transportation difficulties.
      - Youth tended to drop from the program after a first paycheck.
      - Youth did not attend the program if they didn't feel they were doing well.
      - Youth did not consistently access all programs at the expected volume and, consequently, the outcomes were difficult to achieve.

   c. Measuring outcomes/performance was an issue:
      - Database was not operational until six months into the first year of contract.
      - Data were tracked inconsistently and did not produce the consistent measurements or results.

6. **Program Cost-Effectiveness:**

   TAY Academy had a total of 818 unduplicated youth attend five TAY Academy sites and 17.5 direct-staff positions which is a direct staff-to-TAY ratio of 1 to 47. It should be noted that the unduplicated youth goal for the fiscal year 2012-2013 was 200, which would have been a direct staff-to-client ratio of 1 to 11. Cost per client was 1,962.14 dollars (1,605,030.52 dollars for 818 youth).

Next Steps/Recommendations

Program evaluation outlined the need for additional learning with modifications to the current program design.

Mental Health Services Act Innovations Projects
INN-08 Independent Living Facilities Evaluation 2013

Program Name: **Community Health Improvement Partners – Independent Living Facilities**
Program Start Date: **July 1, 2012**
Program End Date: **June 30, 2015**

Purpose

1. **Purpose:**
   a. To promote the highest quality Independent Living (IL) home environment for adults with severe mental illness, and to promote support, wellness, and recovery to IL residents.
   b. The Independent Living Association (ILA) represents the core of the Independent Living Facilities (ILF) Project. The ILA includes criteria for membership, rating levels for facilities based on adherence to ILA quality standards, education for IL owners and residents, membership development, and a focus on sustainability.

2. **Explanation of Purpose:**
   The ILA is a free, voluntary membership organization for IL owners with membership benefits.

Learning Objectives

1. **Learning Objective (#1): Create a set of quality standards for IL homes.**

What We Hoped to Learn: IL owners would be open to ILA membership and thereby adopt a baseline level of quality standards that all IL members would adhere to in order to create a better standard of living for IL residents.

What We Learned: To date, there are 24 active members and several more that are still going through the membership process. IL owners have worked or learned to successfully collaborate with other community organizations, law enforcement partners, hospitals and behavioral health partners. Having established standards has been critical to program success.

2. **Learning Objective (#2): Create an ILA Online Directory to include an online database of ILA-approved homes, and to provide exclusive tools and resources to IL owners to help them improve the quality of their business.**

What We Hoped to Learn: Behavioral health consumers, family members and the larger community would utilize a searchable online database that would provide a centralized resource to help consumers, family members, and the larger community to find information about the quality of the IL options in the county. ILA members would utilize the online directory to provide marketing opportunities and referral sources for owners.

What We Learned: The online directory is successfully being utilized according to its design. According to the Google Analytics data cited from the ILA's term one evaluation report, the results thus far have been promising. According to the data, the site has had 3,400 visits: 58.7 percent were first-time visitors and 41.3 percent were returning visitors.

3. **Learning Objective (#3): Create a Quality Measures and Peer Review Accountability Team (PRAT)**

What We Hoped to Learn: The ILA quality standards (developed by the ILA work team) would create a foundation for ensuring transparency and consistency in the process of determining which IL homes qualify to be ILA members. Through these quality standards, the ILA hopes to improve outcomes for IL residents and help residents, their families, and service providers choose the most appropriate and acceptable housing option. PRAT is made up of owners and residents, and serves to ensure that all ILA members adhere to the quality standards and provide ongoing feedback.

What We Learned: Since the program's inception, there have been 20 PRAT inspections. Sixteen homes met the quality standards on the first inspection and four were advised to make changes to meet the standards. PRAT is able to provide support to the homes that do not meet the standards. Constant review and comparison of inspections has helped PRAT standardize inspections and make improvements on the current inspection process.

4. **Learning Objective (#4): Provide ongoing education and training for IL owners and residents.**

What We Hoped to Learn: Providing education and training on an ongoing basis for both IL owners and residents will help improve the standards of IL homes and promote high quality facilities. The training programs are designed to increase knowledge about IL homes, ILA Quality Standards, and other topics that contribute to increasing the quality of IL operations for owners and residents.

What We Learned: Since the program's inception, the ILA has conducted 32 training courses for participants, including: 104 owners, 167 residents, 51 trainers, and 217 community members. Results from the pre- and post-tests indicate positive results and exceed the contract's outcome objectives. Based on evaluations, training participants indicated that they were very satisfied with the course content and trainers.

5. **Learning Objective (#5): Advocacy and Systems Change**

What We Hoped to Learn: An advocacy and systems change component will focus on educating policy makers and community members in order to reduce discrimination and ensure that the rights of IL owners and IL residents are protected.

What We Learned: To be determined as this will be more of a focus in term two.

Analysis of Program Effectiveness

This program has an end date of June 30, 2015; an analysis of program effectiveness will be conducted upon the conclusion of the program.

Next Steps/Recommendations

Yet to be determined as program continues through the fiscal year 2014-2015.

Mental Health Services Act Innovations Projects
INN-09 Health Literacy Evaluation 2013

Program Name: **Health Literacy- Implementation on Hold**
Program Start Date: **N/A**
Program End Date: **N/A**

Mental Health Services Innovations Projects
INN-10 In-Home Outreach Teams (IHOT) Evaluation 2013

Program Name: **In-Home Outreach Team Program**
Program Start Date: **January 2, 2012**
Program End Date: **December 31, 2014**

Purpose

1. **Purpose:**
   The purpose of the mobile In-Home Outreach Teams (IHOT) is to provide in-home outreach and engagement services to individuals with Severe Mental Illness (SMI) who are reluctant to seek outpatient mental health services, and to their family members or caretakers.

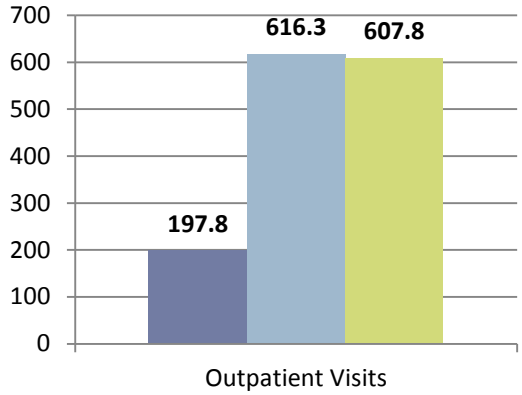
2. **Explanation of Purpose:**
   IHOT teams will provide in-home assessment, crisis intervention, short-term case management, and support services (including information and education about mental health services and community resources; linkages to access outpatient mental health care; and rehabilitation and recovery services among others) to individuals with SMI and their family or caretaker, as necessary. These services are expected to increase family member satisfaction with the Mental Health System of Care, as well as to reduce the effects of untreated mental illness in individuals with SMI and their families.

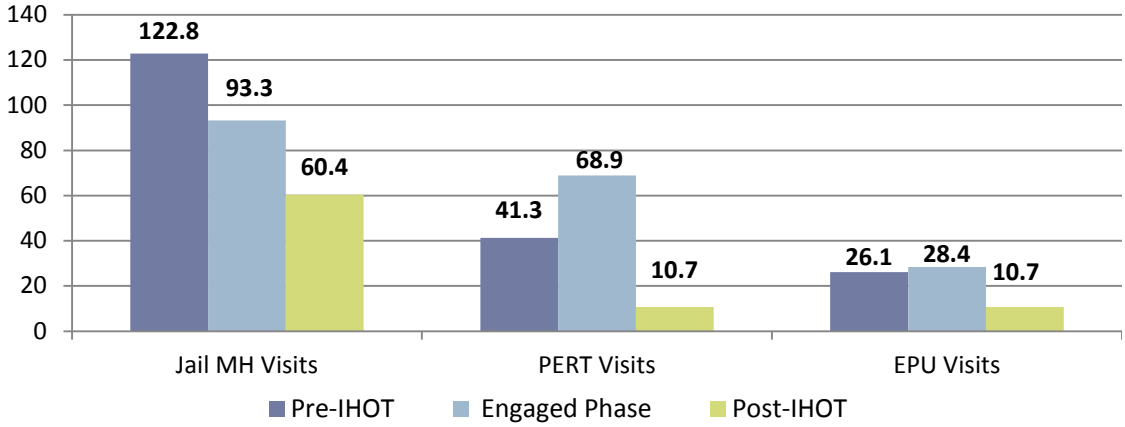
Learning Objectives

1. **Learning Objective (#1): Providing an in-home outreach and engagement service will allow individuals with SMI, who have resisted traditional means of accessing services, a greater knowledge of the system and be more comfortable accessing or accepting outpatient mental health services.**

What We Hoped to Learn: By providing this service, individuals with SMI would be more likely to access or accept outpatient mental health services, thus reducing unnecessary hospitalization and/or criminal justice interaction, and would reduce the instances of individuals with SMI "falling through the cracks".

What We Learned: The service utilization patterns suggest that participation in IHOT is associated with the desired trends of increased outpatient mental health treatment and reduced utilization of the high severity, high need services such as PERT, EPU, and hospitalization as noted in the charts below.





2. **Learning Objective (#2): Bringing services to the participant and family will increase family member knowledge of and enhanced satisfaction with the mental health system of care.**

What We Hoped to Learn: By providing these outreach and education services, families will have a better understanding of the mental health system and how best to approach acquiring needed services for their loved one as well as experiencing a sense of support and encouragement.

What We Learned: Results of the received satisfaction surveys indicate that out of 9 family members who completed the satisfaction question, 100 percent agreed with the statement, "Overall, I/we are satisfied with the services my/our family member received here", with 66.7 percent strongly agreeing. Out of 7 participants/family members who completed the satisfaction question, (100 percent) agreed with the statement, "Overall, I am satisfied with the services I received here", with 85.7 percent strongly agreeing. In addition, the program has received numerous letters from family members thanking the program for the assistance received by IHOT.

Analysis of Program Effectiveness

1. **Changes or Modifications during Implementation:**
   According to the workloads, it was determined that an additional 1.0 full-time equivalent (FTE) data analyst would be needed to track the data provided by the field staff.

Demographics of IHOT participants: males comprised the majority of persons accepted into IHOT (58.6 percent). Caucasian was the most common racial/ethnic category (62.1 percent). Approximately three quarters (75.6 percent) of the IHOT participants were between 25-59 years old, with some representation among both TAY and older adults. Schizophrenia/Schizoaffective Disorder represented the most common diagnosis for the IHOT participants (52.3 percent), followed by Bipolar Disorder (17.2 percent). Slightly over a third (36.8 percent) were identified as likely having a substance abuse related disorder. Referrals came from many sources, but referrals from family members were most common (54.6 percent).

2. **Impact on Participants:**
   With the addition of a data analyst, staff time was freed up to allow more time in the field interacting with participants, and clinical staff had more time for necessary case consultation and supervision with staff about participant and family situations.

3. **What Was Learned:**
   The program services have been very well received in each of the regional catchment areas. Knowledge of the IHOT services has become widespread, with over 30 percent of incoming referrals coming from outside of the program's catchment areas. It is evident that there is a need for these services to be available in all County regions.

4. **Recommended for Replication? YES**
   The program would benefit from an additional 1.0 FTE licensed clinician to be available for face-to-face screening should a participant be eligible and amenable to receiving services. Services should also be available Countywide.

5. **Lessons Learned in Implementation:**
   See narrative above.

6. **<u>Program Cost-Effectiveness</u>:**

   It was determined that additional data staff was needed to maintain the expected scope. In addition to administrative staff, three IHOT teams each consist of a case worker, a peer staff, and a family coach. Moving forward, there will be an additional licensed clinician to provide the face-to-face screening of those deemed eligible. Unfortunately, the number of **family** members served was not tracked in the initial year of the program, only the identified participants who were referred, accepted for outreach, and engaged. Therefore, the metric for the initial year of the program (dividing budget/participants) is not inclusive of everyone served. For year one of the program, 174 participants were accepted into the program. Budget for year one (less startup costs) = 1,109,097 dollars/174 = 6,374 dollars per participant on average.

Next Steps/Recommendations

Program evaluation outlined need for additional learning through a continuance of current program for a designated time period.